STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

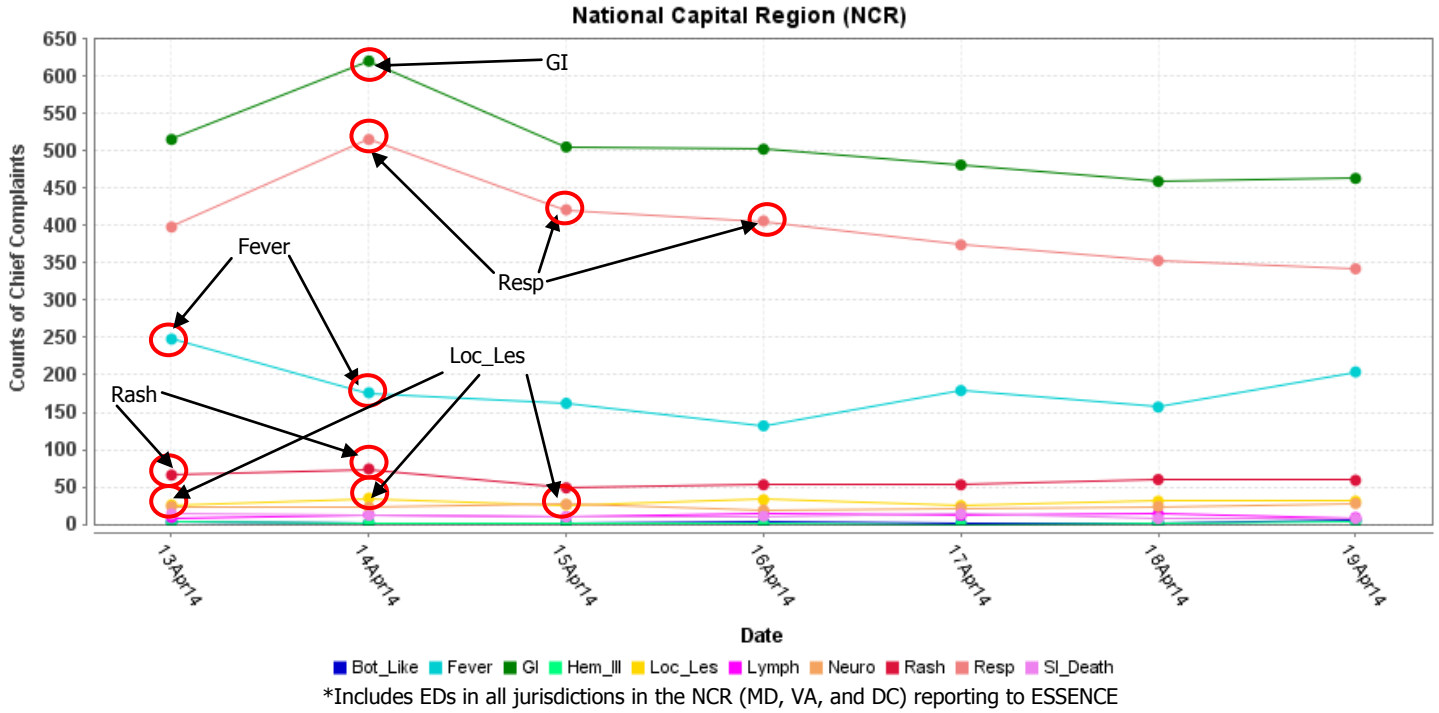
April 25, 2014

Public Health & Emergency Preparedness Bulletin: # 2014:16
Reporting for the week ending 04/19/14 (MMWR Week #16)

CURRENT HOMELAND SECURITY THREAT LEVELS

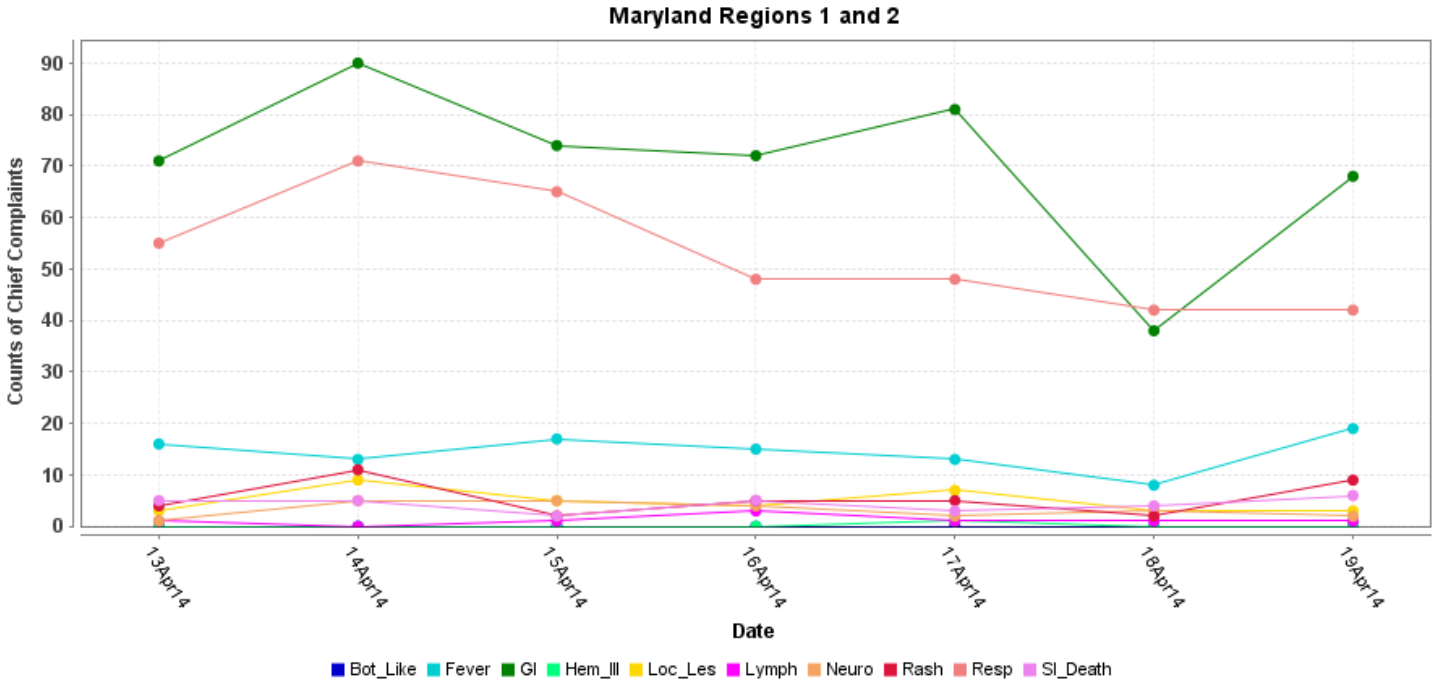
National: **No Active Alerts**
Maryland: **Level Four (MEMA status)**

SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.
Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

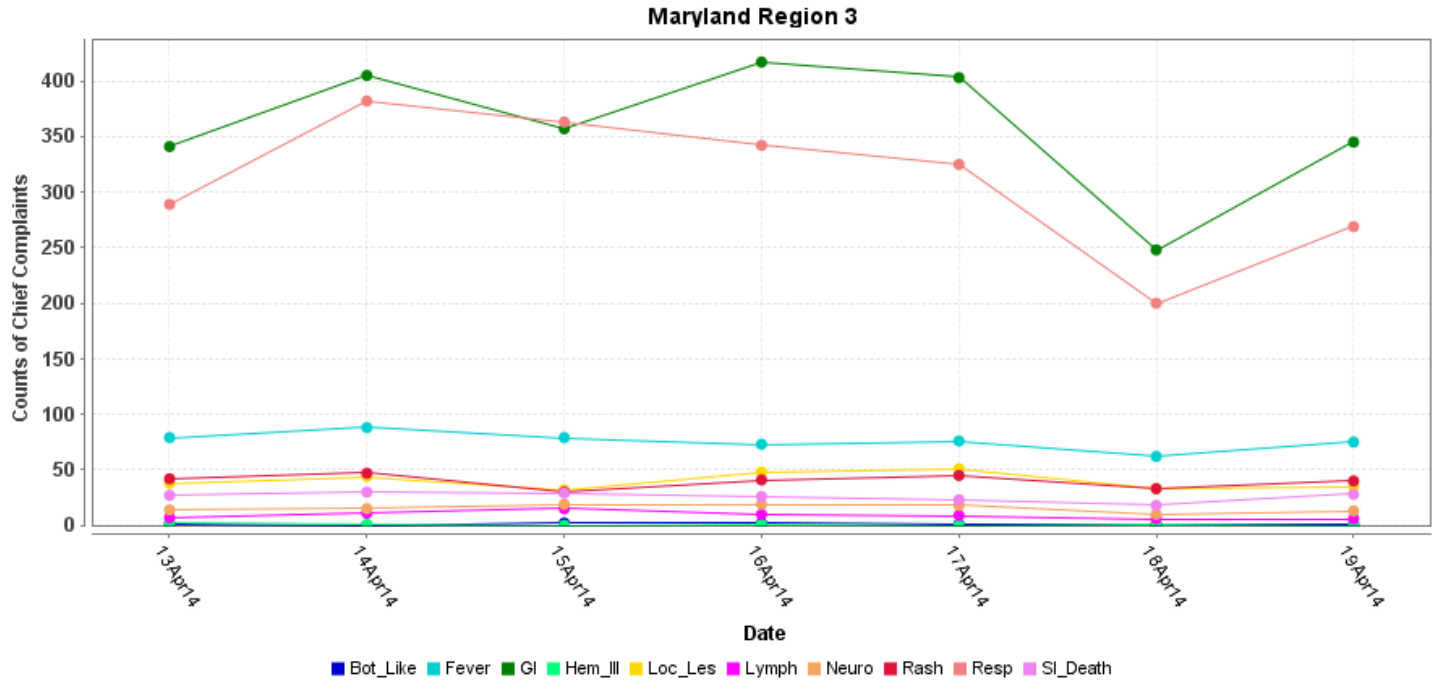


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

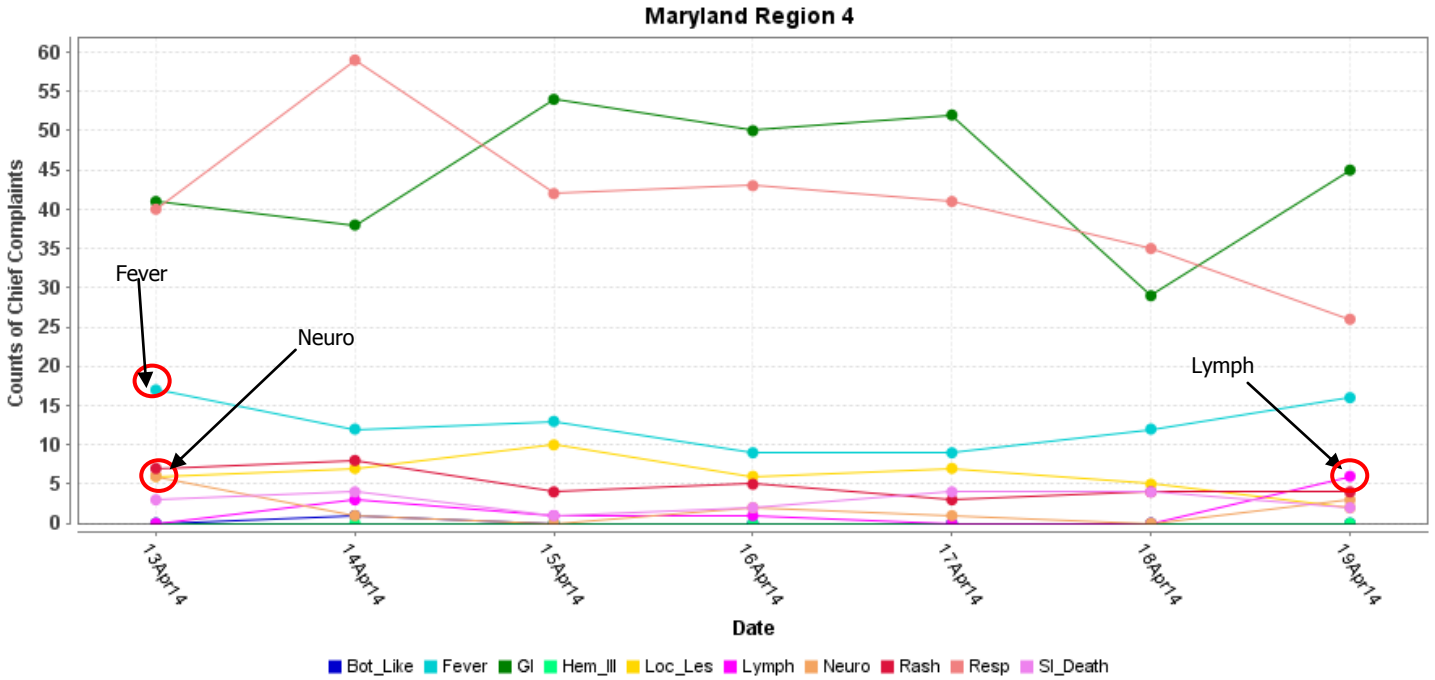
MARYLAND ESSENCE:



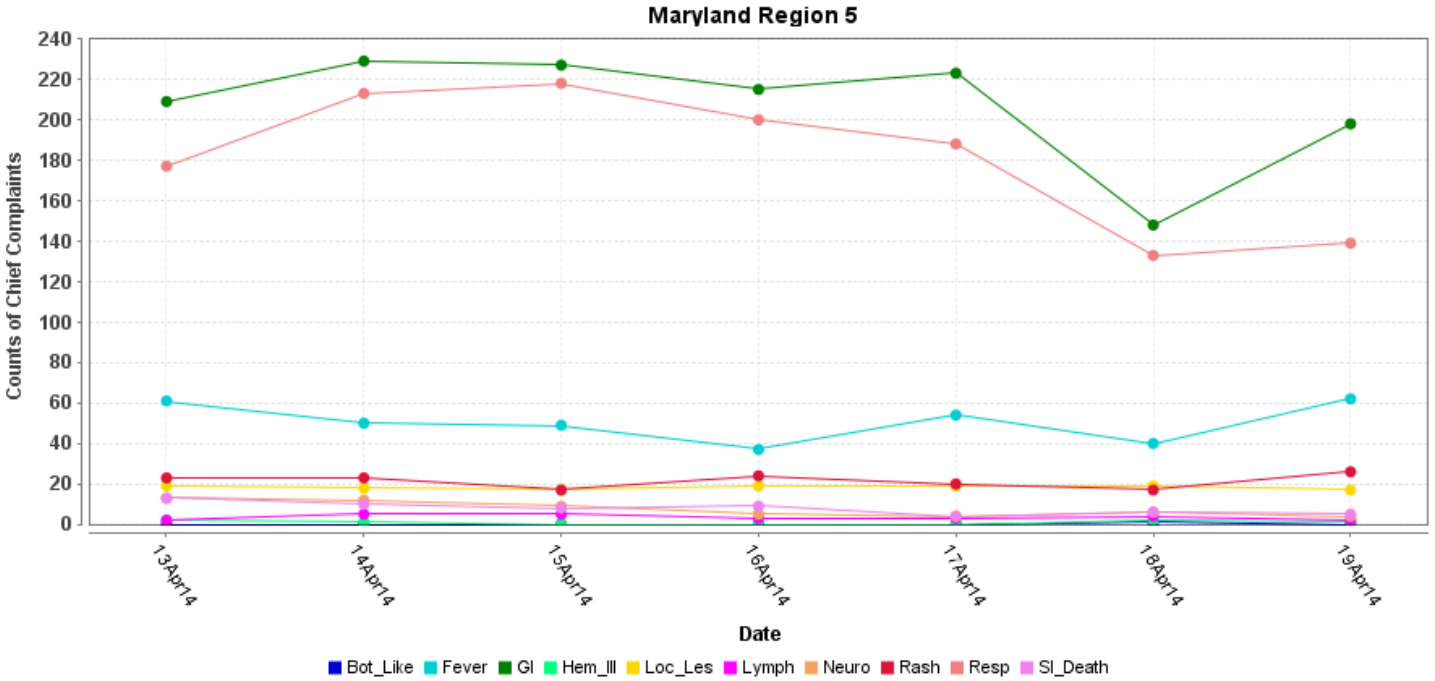
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



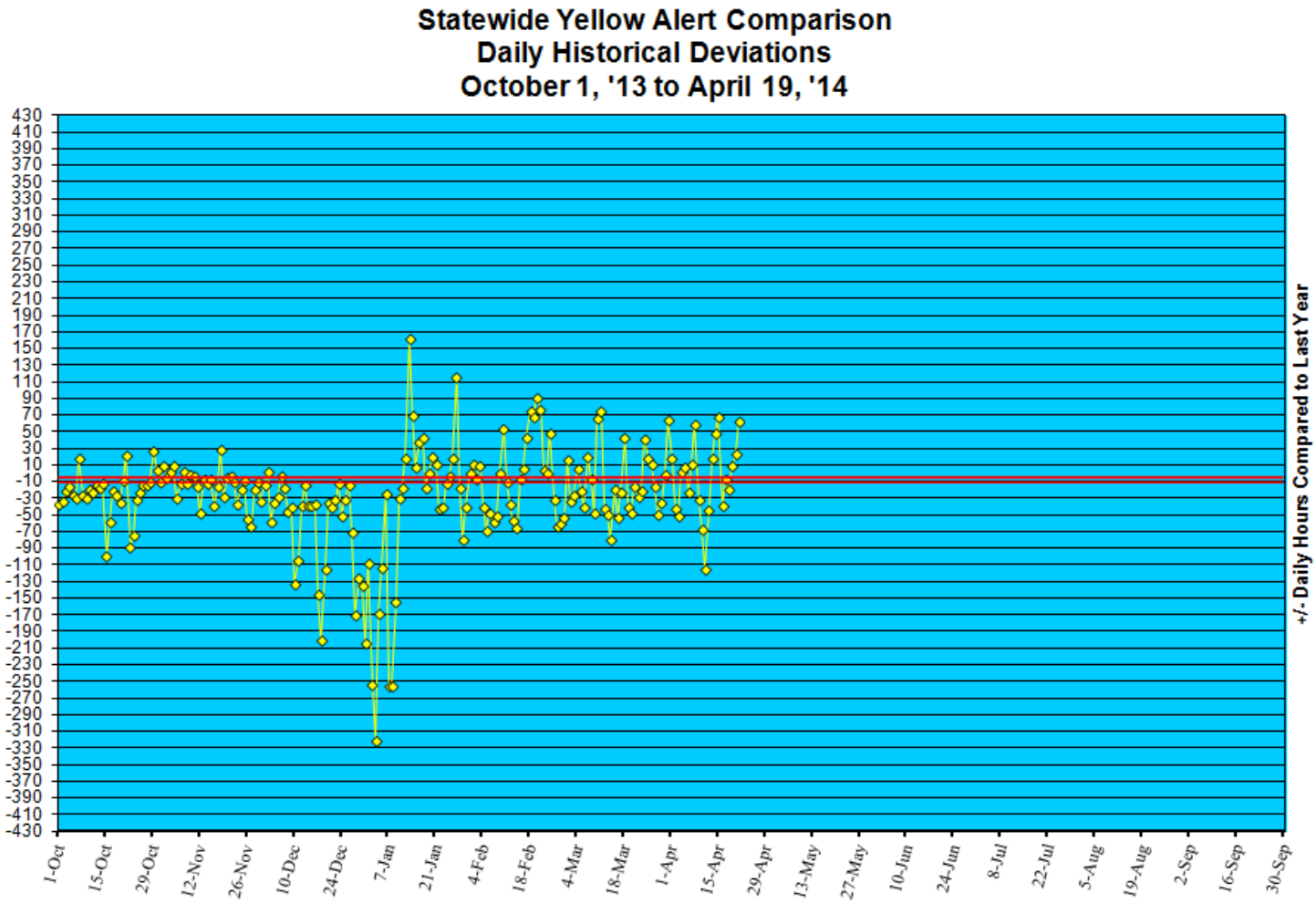
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/13.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in March 2014 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (April 13 - April 19, 2014):	5	0
Prior week (April 6 - April 12, 2014):	9	0
Week#16, 2013 (April 14 - April 20, 2014):	5	0

4 outbreaks were reported to DHMH during MMWR Week 16 (April 13-19, 2014)

3 Gastroenteritis Outbreaks
2 outbreaks of GASTROENTERITIS in Nursing Homes
1 outbreak of GASTROENTERITIS in an Assisted Living Facility

1 Foodborne Outbreak
1 outbreak of GASTROENTERITIS/FOODBORNE associated with a Convention Center

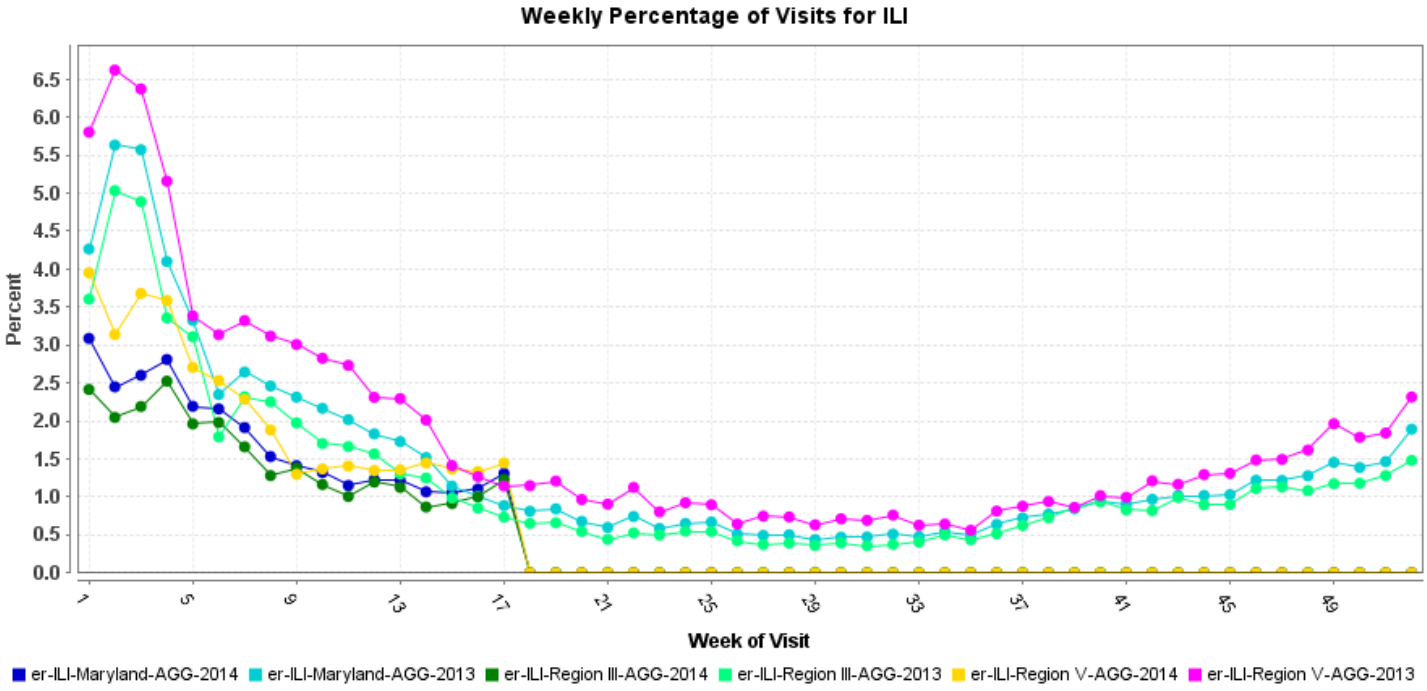
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May. Seasonal influenza activity for Week 15 was: Local with Minimal Intensity.

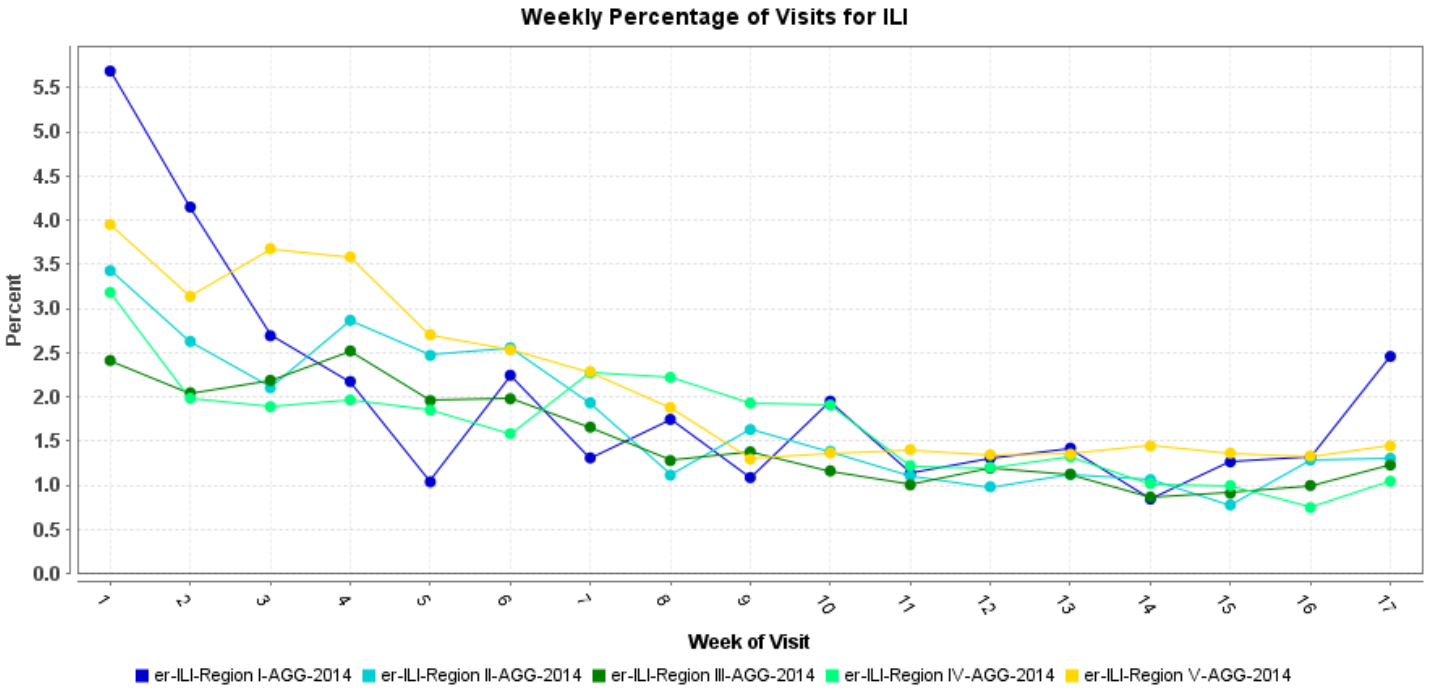
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



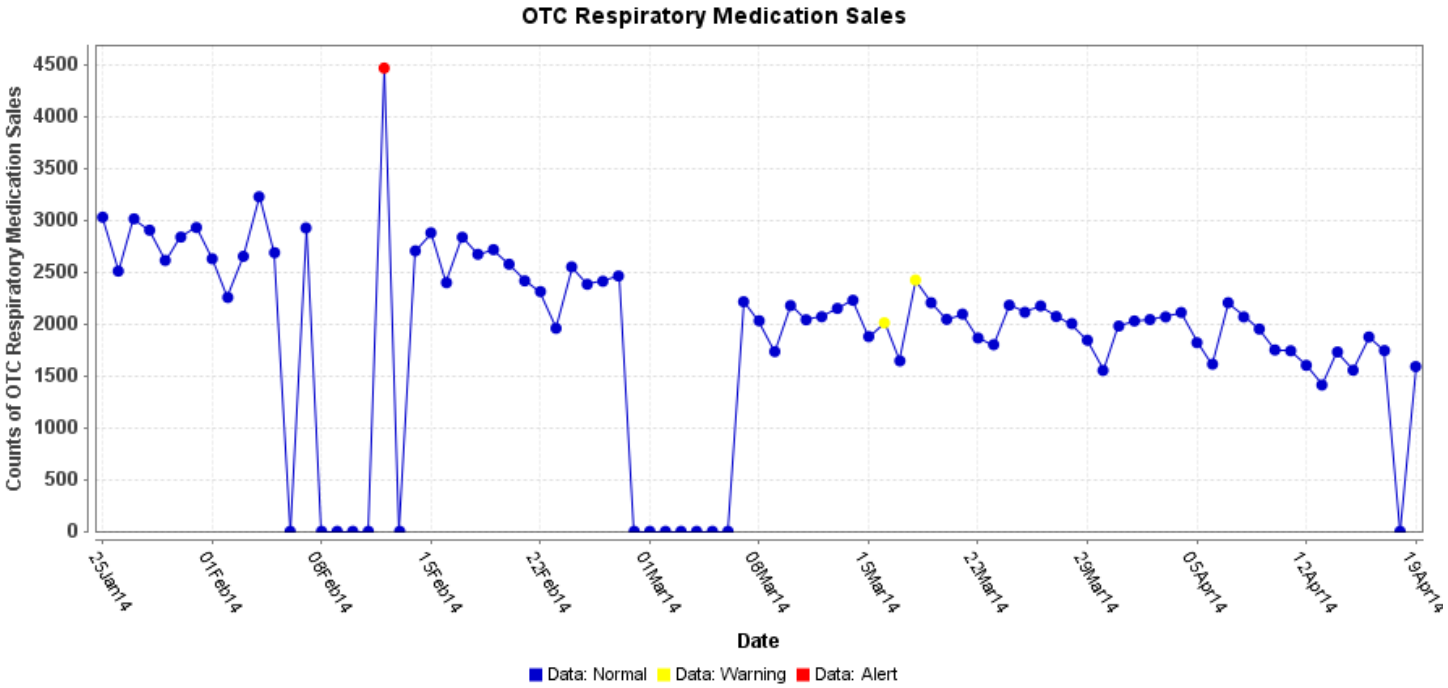
* Includes 2013 and 2014 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2014 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

Alert phase: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of January 24, 2014, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 650, of which 386 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

AVIAN INFLUENZA (H7N9): The Centre for Health Protection (CHP), Hong Kong, SAR, China and the National Health and Family Planning Commission (NHFPC) of China recently notified WHO of 2 additional laboratory-confirmed cases of human infection with avian influenza A(H7N9) virus.

Details of the laboratory-confirmed case reported by the Centre for Health Protection (CHP), Hong Kong SAR, China on [13 Apr 2014] are as follows:
- An 85 year-old woman from Hong Kong with underlying medical conditions. She travelled to Dongguan, Guangdong Province, from [4 to 5 Apr 2014] and stayed with a relative who raised chickens. The patient also visited a wet market located near her relatives' home and helped in slaughtering chickens on [4 Apr 2014]. She returned to Hong Kong on [5 Apr 2014], became ill on [11 Apr 2014] and was admitted to a hospital on [13 Apr 2014]. She is currently in a critical condition. The CHP is currently conducting investigations and contact tracing.

Details of the laboratory-confirmed case reported by the National Health and Family Planning Commission (NHFPC) of China on 14 April are as follows:
- A 52 year-old man from Changzhou City, Jiangsu Province. He became ill on [10 Apr 2014], was admitted to a hospital on [13 Apr 2014] and is currently in a severe condition.

NATIONAL DISEASE REPORTS*

SALMONELLOSIS, SEROTYPE HEIDELBERG (USA): 16 April 2014, As of 7 Apr 2014, a total of 524 individuals infected with the outbreak strains of Salmonella [enterica serotype] Heidelberg have been reported from 25 states and Puerto Rico since 1 Mar 2013. Most of the ill persons (76 percent) have been reported from California. Since the last update on 3 Mar 2014, a total of 43 new ill persons have been reported from [6] states: Arizona (2), California (34), Michigan (1), Oregon (3), Texas (2), and Washington (1). Among 518 persons for whom information is available, illness onset dates range from 1 Mar 2013 to 18 Mar 2014. Ill persons range in age from less than one year to 93 years, with a median age of 18 years. 51 percent of ill persons are male. Among 437 persons with available information, 162 (37 percent) reported being hospitalized. 13 percent of ill persons have developed blood infections as a result of their illness. Typically, approximately 5 percent of persons ill with salmonellosis develop blood infections. No deaths have been reported. Illnesses that began after 8 Mar 2014, might not be reported yet due to the time it takes between when a person becomes ill and when the illness is reported. This takes an average of 2 to 4 weeks. In interviews, ill persons answered questions about foods consumed and other exposures during the week before becoming ill. 310 (86 percent) of 361 ill persons interviewed to date report consuming chicken in the week before becoming ill. Among those who had brand information available, 119 (74 percent) of 161 ill persons reported that they had consumed Foster Farms brand chicken or another brand likely produced by Foster Farms. CDC and state and local public health partners continue to focus the investigation on interviewing ill persons about foods eaten and other exposures before becoming ill, continuing laboratory surveillance through PulseNet to identify additional ill persons who have infections with outbreak-associated strains, and testing recent outbreak strains for antibiotic resistance. CDC is working closely with USDA-FSIS, which is assessing interventions implemented at Foster Farms facilities to prevent future illnesses. CDC's NARMS laboratory continues to conduct antimicrobial susceptibility testing on clinical isolates collected from ill persons infected with any of the 7 outbreak strains. Of 61 isolates tested to date, 38 (62 percent) exhibited resistance to one or more antibiotics. 19 (31 percent) of the 61 isolates were multidrug resistant. To date, isolates collected from ill persons were resistant to combinations of the following antibiotics: ampicillin, chloramphenicol, gentamicin, kanamycin, streptomycin, sulfisoxazole, and tetracycline. Although these antibiotics are not typically used to treat Salmonella bloodstream infections or other severe Salmonella infections, antibiotic resistance can be associated with a higher risk of hospitalization in infected individuals. Isolates collected from ill persons reported in 2014 have exhibited similar patterns of antibiotic resistance as isolates collected from ill persons reported in 2013. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS*

EBOLA VIRUS DISEASE (WEST AFRICA): 19 April 2014, As of 18:00 on 17 Apr 2014, the Ministry of Health (MOH) of Guinea has reported a cumulative total of 203 clinical cases of Ebola virus disease (EVD), including 129 deaths. To date, 158 patients have been tested for ebola virus infection and 109 cases have been laboratory confirmed, including 61 deaths. In addition, 41 cases (34 deaths) meet the probable case definition for EVD and 53 cases (34 deaths) are classified as suspected cases; 24 health care workers (HCW) have been affected (18 confirmed), with 15 deaths (11 confirmed). Clinical cases of EVD have been reported from Conakry (50 cases, including 20 deaths), Guekedou (120/83), Macenta (22/16), Kissidougou (6/5), Dabola (4/4) and Djingaraye (1/1). Laboratory confirmed cases and deaths have been reported from Conakry (36 cases, including 15 deaths), Guekedou (58/34), Macenta (13/10), Kissidougou (1/1) and Dabola (1/1). These updated figures include 4 new cases isolated on 17 Apr 2014, one of whom is laboratory confirmed, and 4 deaths among existing cases; 3 of the deaths were patients with confirmed EVD; 29 patients are currently in isolation in Conakry (17), Guekedou (11) and Macenta (1), while 15 patients who recovered from their illness were discharged from hospital. The female:male ratio among

confirmed cases is 1.2 : 1. The median age of 198 clinical cases for whom the age is known is 35 years and the age breakdown is 0-19 years (11 percent), 20-59 years (72 percent) and 60 and over (11 percent). Contact tracing activities continue in all affected areas. A total of 230 contacts are currently under medical observation and 53 have completed their 21 days of follow-up; 7 contacts who developed symptoms continue in isolation as a precautionary measure. Efforts to increase public health awareness continue. The Ministry of Foreign Affairs of Guinea convened a meeting with a number of diplomatic missions on 18 Apr 2014 where the Minister of Health, supported by the WHO Representative, WHO Country Office for Guinea, and WHO EVD Response Coordinator, briefed the meeting. WHO and the Global Outbreak Alert and Response Network are in the process of deploying additional experts to support activities in case management, infection prevention and control, contact tracing, social mobilization and psychosocial support. Numbers of cases and contacts remain subject to change due to consolidation of cases, contact and laboratory data, enhanced surveillance and contact tracing activities and the continuing laboratory investigations. In Liberia, the epidemiological situation remains the same. Intensive surveillance activities and other preventive measures are ongoing. No new laboratory confirmed cases of EVD have been reported from Liberia today. WHO does not recommend that any travel or trade restrictions be applied to Guinea or Liberia based on the current information available for this event. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

MERS-CoV (GREECE): 19 April 2014, The HCDCP [Hellenic Center for Disease Control and Prevention] inform a laboratory confirmed case of infection with MERS-coronavirus [MERS-CoV] in a 69-year-old patient, a Greek resident of Saudi Arabia, who is hospitalized in stable condition. The clinical picture of the patient was reviewed after arriving in our country on [17 Apr 2014] from Jeddah, Saudi Arabia, because of prolonged fever for which [the patient] was [evaluated] at the district hospital. Due compatible clinical and epidemiological history of the patient was tested and found positive in 2 consecutive molecular tests in the Greek Pasteur Institute. The HCDCP has taken all necessary actions to track and monitor the contacts of the patient both during the voyage to Athens, in cooperation with the Civil Aviation Authority, the Aerougeionomeio [?] and the airline, and during his stay in Greece in collaboration with the hospital inpatient [service], where they have done the necessary actions. All measures to prevent and control spread of the disease to safeguard public health in accordance with the guidelines of HCDCP, the European CDC and the World Health Organization (WHO) have already been implemented. The patient with actions of the National Health Operations Centre (CERECO) is transferred to a special unit of respiratory diseases. As already mentioned in our previous update (press release [3 Jun 2013]), the MERS-CoV is a new member of the family of coronaviruses, which in 2012 was recognized as pathogenic for humans. The coronaviruses include both viruses that cause the common cold, and that cause the syndrome SARS. This new virus has no direct relationship with any of the other known coronaviruses, but disease is accompanied by significant mortality. Up through [17 Apr 2014], the WHO has announced there have been a total of 243 laboratory confirmed cases of MERS-CoV including 93 deaths. The most recent WHO information included information on 17 Apr 2014 concerning a traveler from Jeddah to Malaysia. The Greek case is the 10th case of infection with MERS-CoV diagnosed in Europe (in 5 different European countries: United Kingdom, Germany, France, Italy). Up through today [17 Apr 2014], confirmed cases of the disease have presented with mainly acute respiratory infection with fever, cough, and dyspnea, it is of critical importance to highlight the need for the application of strict rules of infection control to prevent the spread of infection in the hospital environment. The precautionary measures recommended for protection against MERS-CoV are those applicable to other viral respiratory infections, namely to avoid close contact with people who show symptoms of the disease (coughing, sneezing) and have recently traveled to areas at risk (Arabian Peninsula). It highlights the search prompt medical evaluation in travelers returning from the Arabian Peninsula and exhibit similar symptoms within 14 days of their arrival. The HCDCP is constantly vigilant regarding any further incidents detection in hospitals in the country. Under the International Health Regulations (IHR) and the EU obligations of the country HCDCP has been updated through the Early Warning System (EWRS), the European CDC (ECDC), and the World Health Organization (WHO) about the incident and the steps taken in our country. The HCDCP informs that in accordance with international epidemiological data and because they have taken in our country all appropriate public health measures, spread of the disease is not expected and there is no reason for concern for the general population. (Emerging Infectious Diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

HANTAVIRUS (PANAMA): 19 April 2014, A new case of hantavirus pulmonary syndrome [HPS] was confirmed by the Epidemiology Office of the Ministry of Health, raising the number of cases to 16 so far this year [2014]. The patient, a 50-year-old woman from La Enea, Guarare district in Los Santos province, is in serious condition in the intensive care unit. It is worth mentioning that the woman is the sister of a patient who died of the same condition in the year 2000. The Director General of Health, Carlos Galvez, stated that new cases have not been reported for several weeks, which indicates that there still may be [new] infections because the rodent is circulating [the virus], and preventive measures must be maintained. (Emerging Infectious Diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

LEPTOSPIROSIS (INDONESIA): 18 April 2014, Boyolali district, Central Java [Jawa Tengah], said there was a leptospirosis outbreak following the death of 5 residents from the deadly disease in the area. "We consider there was an outbreak of the leptospirosis disease, because the disease had caused the death of 5 infected people in Nogosari and Ngemplak," Boyolali Health Office chief Yulianto Prabowo said here on Wednesday [16 Apr 2014]. Yulianto said the leptospirosis cases had been prevalent in Boyolali since 2012, with only 2 infected people in the Ngemplak sub-district. Previously in 2011, there were reports of 6 people being infected from leptospirosis in Nogosari and Ngemplak, who were successfully cured. Leptospirosis cases were again reported in 2014, when 4 people in Nogosari and 2 others in Ngemplak sub-districts were found to be suffering from the disease. Therefore, from this leptospirosis outbreak, the Boyolali Health Office is expected to increase its prevention effort before the disease spreads to other areas. The Boyolali health office is working together with the Development Research Institute of Animal Borne Disease Control and the Banjarnegara Health Ministry office to handle the disease. "We are conducting studies in an effort to anticipate leptospirosis by examining the disease, its treatment and the rat population increase in the affected area," he said. Leptospirosis is an infection caused by the *Leptospira* bacteria. Symptoms can range from none to mild, such as headaches, muscles pains, and fevers, to severe with bleeding from the lungs or meningitis. The disease is transmitted by both wild and domestic animals. The most common animals to spread it are rodents. It is often transmitted by animal urine or water containing animal urine coming into contact with breaks in the skin, the eyes, mouth or nose. "Cattle or animals besides rats, such as cats, cows, and goats, are also susceptible of contracting the disease as carriers," Yulianto said. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

CRIMEAN-CONGO HEMORRHAGIC FEVER (TURKEY): 18 April 2014, The Crimean-Congo hemorrhagic fever (CCHF) virus was found in the blood of a person who died on Sunday [13 Apr 2014] in Turkey's Istanbul. According to information given to an AA correspondent, a 56-year-old man, who ranches in Kavak village of Boyabat district [Sinop province], removed ticks on his bovine animal on 4 Apr [2014]. On the following day, he was given serum [IV fluids?] after he went to hospital with complaints of weakness and vomit. He went to a hospital again in Kastamonu city, then he was sent to Istanbul with suspected CCHF. However, he lost his life despite all efforts. The man's blood samples were sent to a laboratory, [found the CCHF virus in it]. Sinop Public Health Director Dr. Tahsin Gokhan Telatar told AA that the test results of the blood samples show that the man died due to CCHF. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

FOODBORNE ILLNESS (YEMEN): 17 April 2014, Food aid allocated to al-Dali by the World Food Program [WFP] has caused the deaths of 2 children and injured dozens more as a result of eating beans that likely gave them a deadly disease. Medical sources say that more than 20 children arrived at the hospital in critical condition, and Dr. Nabil Barti says that the cause of death was the beans, though the disease is still unknown. Dr. Barti says that the children died of severe anemia, which reduced the effectiveness of their red blood cells by a factor of 2 or 3, followed by acute renal failure. He explained that the Health Bureau is currently investigating the WFP beans to determine the type of disease. The WFP has begun distributing more than 18,000 food baskets in order to aid those displaced by violence in al-Dali. National Yemen contacted the WFP, which said that it takes this report very seriously and that the safety of its commodities are of paramount importance. It will investigate the claim thoroughly. All WFP food is checked to ensure that it meets international standards, and all food is additionally certified by the Yemen Bureau of Standards. WFP is conducting an investigation in collaboration with the Ministry of Health, and to date, sees no indications that its food is hazardous. On the other hand, the Epidemiological Monitoring Center in al-Dali said that more than 50 cases of the diseases have appeared not only in al-Dali, but also al-Azariq. Most symptoms affected children between 5-15 and consisted of fever, blood in urine, severe diarrhea, as well as anemia, according to a confidential source. It has not been confirmed whether the beans were infected by pollution or a virus, but the source said that citizens should stop eating the beans and call the relevant authorities in the Ministry of Health to find out the truth. The source explained that not all people may become infected, as the beans were eaten in the past to no effect. He advised waiting before making any claims on the matter. Dr. Ameen Abeed Obasi, an internal medicine specialist at the hospital, confirmed these cases. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

CHOLERA (COLOMBIA): 17 April 2014, More than 400 inhabitants of the municipality of Bajo Baudo (Choco) are apparently affected by a bacterium that is in the water and which has led to the health center of the town being on the highest alert. The mayor of Bajo Baudo said that the affected persons had vomiting, diarrhea, and high fever and that only the most serious cases are being treated in the health center, while the remaining should remain at home. The trustee sought the assistance of the national government. The mayor stated that this epidemic cannot be left without attention. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

FOODBORNE ILLNESS (VIET NAM): 16 April 2014, 22 people in the northern mountainous province of Lao Cai were poisoned after eating horse-blood pudding at a party. Test results of the horse blood pudding showed that staphylococci and E. coli were present in the dish, which is popular with Hmong and other ethnic farming people in the mountains. The poisoning cases were announced by the Viet Nam Food Administration on 13 Apr 2014. Health authorities in Lao Cai Province have taken samples for testing. 53 people participated in the party, and 22 of them were affected. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

FOODBORNE ILLNESS (MEXICO): 15 April 2014, As a result of the poisoning of 220 customers, the State Commission for the Protection against Sanitary Risks (Cofepris) has suspended 8 restaurants, a distribution center, and 2 suppliers of the "Que Rollo Sushi" chain, which produces sushi rolls. "After eating at these businesses, 220 people were reported ill in 2 separate events", which resulted in Cofepris initiating an investigation into the quality of the products and sanitary conditions in which the company operates," said the commission in a statement. Among the reasons for the suspension were the lack of control over the temperature and malfunction of the freezers, in addition to the lack of appropriate manuals for food preparation and cross-contamination in the tables for the preparation of the sushi. "The investigation is continuing as the federal inspectors took 36 samples of food and products for microbiological analysis in the laboratory. The results will start to become available next week," added the agency. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

FOODBORNE ILLNESS (GUATEMALA): 15 April 2014, Students in 4th and 5th high school grades of the Escuela Normal Doctor Pedro Molina located in La Alameda, Chimaltenango, became ill yesterday, 10 Apr 2014, after they had consumed chicken, beans, and rice, allegedly in poor condition. The affected students pointed out that on 9 Apr 2014 they went to the capital to watch a play, and that it was the food transported on the grill of the buses that made them I'll. They said that at the end of the cultural activity they had their lunch and noticed that the beans and rice had a bad taste, and that the chicken was not of a normal consistency, but they ate the food because they were hungry. School master Axel Montufar said that on the early morning of 10 Apr 2014, 4 students started with vomiting, diarrhea, and headache; however, within minutes, the discomfort was evident in 335 young people. The ill were evaluated, 185 were transferred to the National Hospital in Chimaltenango and the rest received attention on campus. In the hospital, some young people were hydrated orally; others, intravenously. One student said that on the day of the activity no food was consumed in the capital, and therefore it is likely that the lunch was the cause of the illnesses. Hospital epidemiologist Edgar Barrier said that the respective analysis to determine which microorganism caused the problem are being done, although it is believed to be either E. coli or Salmonella. "We will give some suggestions to the cooks, to take precautions at the time of preparing the food," he said. Gladis Lopez, director of the school, reported that there are 688 students at the school, and all of them eat there. Lopez said that the catering company was contracted by the Ministry of Education and the board of parents, so they will have to request an explanation from the supplier. The students treated at the hospital were discharged from hospital already. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

National and International Disease Reports are retrieved from http://www.promedmail.org/.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/ or follow us on Facebook at www.facebook.com/MarylandOPR.

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

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Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumococcal meningitis, viral encephalitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephalitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents (continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable